STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING _____ B. WING _____	03/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY INC	559 W LONGEST ST PAOLI, IN47454

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F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with Investigation of Complaint IN00086411. Survey Dates: March 1 - 4, 2011 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Survey Team: Debora Barth, RN, TC Brenda Buroker, RN Donna Downs, RN Lois Corbin, RN Census Bed Type: SNF: 13 SNF/NF: 87 Total: 100 Census Payor Type: Medicare: 18 Medicaid: 72 Other: 10 Total: 100 Stage 2 Sample: 37 Supplemental Sample: 3 These deficiencies also reflect state	F0000	This plan of correction is to serve as Paoli Health and Living Community's credible allegation of compliance.Submission of this plan of correction does not constitute an admission by Paoli Health and Living Community or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings in accordance with 410 IAC 16.2. Quality review 3/10/11 by Suzanne Williams, RN			
F0164 SS=D	Based on observation and interview, the facility failed to provide privacy to 1 of 1 resident who received pressure ulcer treatment in the therapy room in a sample of 3 residents who met the criteria for pressure ulcers. [Resident #113] Findings include: 1. During observation of pressure ulcer care on 3/3/11 at 9:43 A.M., in the therapy room, PT #1 provided care to Resident #113. The resident was lying on her left side and was receiving diathermy (deep heat therapy to increase circulation to an area). The therapy room was a large, open room and there were five residents receiving treatment in the large room. The resident received care behind a cloth curtain within 4 feet of the other residents. The activity in the open room could easily be heard. The resident cried out in pain during treatment. Following the treatment, interview with PT #1 indicated the resident had previously been treated in her room, but had just been brought to the therapy room the	F0164	F164 483.10, 483.75PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDSI.The resident is now receiving wound care in her room.II.All residents receiving therapy for wound care will have dressing changes completed in their rooms.III.The systemic change is that all residents receiving therapy for wound care will have dressing changes completed in their rooms. All therapists will receive education on personal privacy.IV.The therapy supervisor will observe a minimum of two dressing changes provided by therapy weekly for 4 weeks to monitor that privacy is provided to the resident. The audit will then continue at 2 dressing changes monthly for 11 months. The therapy supervisor will monitor all residents receiving dressing changes by therapy to determine that they are receiving dressing changes in their room. Any identified concerns will be addressed immediately.The results of these reviews will be discussed at the monthly facility Quality Assurance Comittee Meeting and frequency and duration of reviews will be adjusted as needed.	04/03/2011

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	previous day. 3.1-3(o) 3.3-3(p)(2)			

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F0226 SS=C	Based on interviews and record review, the facility failed to develop and implement abuse policy and procedures to include reporting of alleged abuse violations immediately to the Administrator. This had the potential to affect 100 of 100 residents in the facility. Findings include: The abuse policy and procedure was received from the Administrator on 3/2/11 at 3:40 p.m. A review of this policy indicated the following: "Section IV. Identifying And Recognizing Signs And Symptoms Of Abuse Policy Statement. Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services immediately. Section V. Abuse Investigations Policy Statement. All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Section VII. Reporting Abuse To: A. Facility Management Policy Statement It is the responsibility of our employees, facility consultants,	F0226	F 226 483.13 (c)DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC. POLICIESI.The abuse policy has been updated to reflect notifying the Administrator immediately of all allegations of abuse. This was presented to the surveyors during the survey process.II.All allegations of abuse for the last 90 days have been reviewed and the Administrator was immediately notified in all cases.III.The systemic change is that the policy has been updated to reflect that the Administrator will be immediately notified of any allegations of abuse. All staff will be offered education on the updated policy. All newly hired staff will offered education utilizing the new abuse policy upon hire.IV.The facility Administrator will conduct random interviews with staff in regards to the abuse policy. This will occur with a minimum of 10 staff members weekly for 4 weeks and then proceed to 10 staff members monthly for 11 months.The results of this audit will be discussed at the monthly facility Quality Assurance Review meeting and the frequency and duration of the reviews will be adjusted as needed.	04/03/2011

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	attending physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility management." During an interview with LPN #1 on 3/3/11 at 2:03 p.m., she indicated for allegations of abuse she, would report it to the DNS (Director of Nursing Services). On 3/4/11 at 6 a.m., during an interview with LPN #2, she indicated for reported allegations of abuse, she would report to the DNS. During an interview with LPN #3 on 3/4/11 at 1:25 p.m., she indicated for allegations of abuse, she would report to the DNS. 3.1-28(a)			

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F0241 SS=E	Based on observation and interview, the facility failed to ensure residents were treated with dignity related to meals served promptly to ensure temperatures of hot foods were appropriate when served. This affected 8 of 20 residents, who met the criteria as interviewed and expressed concerns for food quality as served (Resident #24, #42, #29, #35, #162, #158, #165, and #6). This also affected 4 of 10 residents observed during the noon meal during 2 of 2 observations of room tray service on 1 of 5 units (100 Unit) of the facility. (Residents #61, #83, #17, and #32). **Findings include:** **1. Resident #24 was interviewed on 3/1/11 at 11:04 a.m. The resident indicated she takes her meals in her room and the food is sometimes served cold.** **2. Resident #42 was interviewed on 3/1/11 at 11:34 a.m. She indicated the food is served cold.** **3. Resident #29 was interviewed on 3/1/11 at 11:40 a.m. She indicated the food served on room trays is not served at the proper**	F0241	F 241 483.15 (a)DIGNITY AND RESPECT OF INDIVIDUALITYI.All residents who expressed concerns with their meal quality have been interviewed regarding their concerns and currently express no issues with the temperatures of meal service. Residents #17, #83, #32 and #61 were individually assessed to determine their needs. Dining services have been adjusted to provided warm, prompt meal service with assistance as needed. Individual interviews reflect that the residents are receiving meals at temperatures that are satisfactory to them.II.Other residents were reviewed either through interview or observation to determine satisfaction with meal service. Any resident with concerns was assessed for appropriate meal service and location of receiving meals. Dining service and staff assignment were adjusted to meet their needs.III.The systemic change is the dining service and staff assignment have been adjusted to meet the residents needs in regards to meal service. Staff has been provided education regarding new assignments to facilitate dining. The facility is encouraging all residents to go to the dining room for meals and providing assistance to those residents who eat in their rooms through nurse	04/03/2011

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	temperature, indicating the food is served cold. **4. Resident #35 was interviewed on 3/1/11 at 11:49 a.m. and indicated the food is served cold everyday. The resident indicated the fried eggs and sausage are cold, and the toast is cold and "hard as a rock."** **5. Resident #162 was interviewed on 3/1/11 at 2:36 p.m. The resident indicated the food is served cooler than she desires.** **6. Resident #158 was interviewed on 3/1/11 at 3:30 p.m. He indicated the food is usually served cold and the staff will heat it, if asked to.** **7. Resident #165 was interviewed on 3/2/11 at 8:31 a.m. She indicated the food was not warm when served, and "eggs should be warm."** **8. Resident #6 was interviewed on 3/2/11 at 11:08 a.m. The resident indicated most of the food is cold, and the resident indicated staff will warm it "if we holler about it - just eat."**		supervision and prompt dining services.IV.The Director of Nursing or her designee will audit meal service and dignity related to meals by random observation of meals on each shift. These audits will occur a minimum of 3 times weekly for 4 weeks and then 1 time weekly for a total of 4 months, proceeding to 1 time monthly for a total of 12 months. The Certified Dietary Manager or her designee will conduct random audits of food temperatures with meal service 3 times weekly for 4 weeks, and then 1 time weekly for a total of 4 months, proceeding to 1 time monthly for a total of 12 months.The results will be discussed in the facility monthly Quality Assurance meeting and the frequency and duration will be adjusted as needed.	

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	9. On 3/1/11 at 11:52 a.m., the meal service was observed on the 100 unit. Resident #17 and #32 were observed with their meals, uncovered, in front of them on overbed tables, while they dozed in their chairs. Resident #61 was in bed, sleeping, with her meal, uncovered, on the overbed table in front of her at this time. At 12:05 p.m., Resident #83 was observed in her bed, with her meal, uncovered, on the overbed table in front of her while she dozed in the bed. At 12:16 p.m., Resident #32 was observed eating her meal while Resident #17 remained dozing in the chair, with her uncovered tray untouched in front of her. At 12:23 p.m., Residents #61, #83, and #17 continued to doze with their meals in front of them, without staff interaction/cueing. At 12:30 p.m., Resident #17 received cueing from staff to eat her meal. At 12:40 p.m., Resident #61 and #83 received encouragement to eat their meals, which had been sitting, uncovered in front of them, since 11:52 a.m. and 12:05 p.m. 10. On 3/3/11, during observation of the noon meal service in the dietary			

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	department, the Dietary Manager indicated there were 56 residents who took their meals in their rooms. 11. On 3/3/11 at 11:22 a.m., the lunch cart arrived on the 100 unit. Two CNAs were observed to serve the trays on the cart. Resident #61 was served at 11:25 a.m. The resident was in bed, and her tray was set on the overbed table in front of her, with the food uncovered. The resident returned to dozing as soon as the CNA left the room. Resident #83 was served at 11:40 a.m. The resident was up in a wheelchair, and her tray was set up in front of her on an overbed table. The food was uncovered, and staff left the room. The resident did not make an attempt to eat any of the food on the tray in front of her and no staff were present to encourage the resident to eat. At 11:47 a.m., two CNAs, one of which assisted serving the 100 unit, began serving the trays from the 300 unit cart. The CNA from the 100 unit indicated all the 100 hall trays were served so she was helping on the 300 unit, leaving 1 CNA on the 100 unit to assist residents taking their meals in their room.			

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	At 11:58 a.m., Residents #61 and #83 remained unchanged; their trays were open in front of them while they dozed in the bed and chair. At this time, the CNA from the 100 unit that went to assist on the 300 unit, went back to the 100 unit to "check with her" (meaning other CNA on the hall) and stated then she would go to the dining room to serve. The CNA left 100 hall at 12:01 p.m. to assist in the main dining room. At 12:05 p.m., Resident #61 remained sleeping with her tray, uncovered in front of her and no staff assistance. Resident #83 was awake in her w/c, with her tray in front of her on the overbed table, but she was not eating and no staff were providing assistance/encouragement. 3.1-3(t)			

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F0248 SS=D	Based on observation, interview and record review, the facility failed to provide activities to meet the resident's interests for 1 of 3 residents reviewed for activities in a sample of 17 who met criteria for structured activities for the cognitively impaired. [Resident #63] Findings include: During observations on 3/3/11 at 8:18 A.M. and 10:45 A.M., Resident #63 was lying in bed in her room. On 3/3/11 at 1:30 P.M., the resident was observed sitting on the side of the bed and had a visitor talking to her. The clinical record of Resident #63 was reviewed on 3/3/11 at 2:40 P.M. and indicated a Minimum Data Set [MDS] assessment for a significant change on 12/29/10. The assessment indicated an interview with the resident for activity preferences: How important is it to you to keep up with the news, do things with groups of people, do your favorite activities, and participate in religious services or practices? The resident indicated these things were somewhat	F0248	F 248 483.15 (f)(1)ACTVITIES MEET INTERESTS/NEEDS OF EACH RESIDENTI.Resident #63 was interviewed and has an updated Activities Care Plan that meets the criteria for structured activities of the cognitively impaired.II.Cognitively impaired residents activities programming has been reviewed for structured activities for the cognitively impaired. Their Activities Care Plan has been updated and reflects the resident's interests.III.The systemic change the Activities Director is attending stand down meeting 5 times weekly to be updated on residents who have changes and may need changes to their activities programming. The facility is updating all resident's activity programming with each MDS to reflect the resident's interests, as well as providing structured activities for the cognitively impaired. The Activities Director has been offered education in this programming and implementation.IV.The Administrator or her designee will monitor the structured programming for a minimum of 10 residents weekly through observation and interview of the staff caring for them for 8 weeks to evaluate if the resident's interests and needs are being met. This audit will then occur a minimum of 10 residents monthly	04/03/2011

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	important to her. The MDS indicated the resident was totally dependent on staff for locomotion off the unit. Interview with the Activity Director [AD] on 3/4/11 at 9:12 AM., indicated the resident had some cognition problems. The AD indicated there was a specific plan for activities which was individualized. Review of the Care Plan, dated 2/16/11, indicated: "Resident involved in activities some of the time from 1/3 to 2/3 of time. Resident is H.O.H. [hard of hearing]. Goal - Resident will express satisfaction with quality and quantity of activities. Interventions: Provide care, activities, and a daily schedule that resembles the resident's prior lifestyle. Involve resident with those who have shared interests. Encourage resident to become involved with activities such as music, special events, church, and socials. Adapt to resident's current abilities. Provide setting in which activities are preferred own room, day room. Inform resident of upcoming activities by providing activity calendar, verbal		for a total of 12 months.The results will be discussed in the facility monthly Quality Assurance Committee meeting and the frequency and duration will be adjusted as needed.	

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	reminders, encouragement. Review of the Activity Progress Notes indicated: On 12/28/10, "Resident is alert and pleasant and able to voice needs and wants to staff. Resident is up daily for meals and activities. Resident has visitors often and family is very supportive. Resident prefers to do independent activities. Will provide materials as needed for independent activities. I will also invite and encourage to participate in group activities. Resident has had no changes in activities since last assessment date. On 1/4/11, "Resident has had no changes since last assessment. Resident enjoys music, socializing, family visits, and spiritual. Will provide resident with materials needed for independent activities. Will invite and encourage to participate in group activities." Interview with CNA #1 on 3/4/11 at 9:30 A.M., indicated the resident has several visitors and has a niece who visited almost every day. The CNA indicated she thought the resident got a little down when the niece was away for the winter. The CNA indicated she thought the resident's hearing			

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	impairment was why she did not enjoy group activities. Interview with the AD at 10:07 A.M. on 3/4/11, indicated she kept a record of room activities and provided the February 2011 calendar. The resident had not attended any group activity and the independent activity tracking log for February 2011 indicated the resident had visitors daily and there were no other activities listed as being done. The Independent Activity Tracking Log indicated, "Utilize this form for residents who do not engage in group activities but are highly involved in independent activities. Place a check mark under each heading that applies according to the date." The AD indicated she had volunteers visit the resident on Fridays, and offered magazines to the resident. On 3/4/11 at 2:30 P.M., the administrator indicated the problem with activities had been addressed and provided a note with the resident's name on it, "enjoys flowers, enjoys poetry reading, and likes having company & visiting." 3.1-33(a)			

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F0279 SS=D	Based on record review and interview, the facility failed to formulate and/or update care plans related to pressure sore treatment/prevention. This affected 1 of 3 residents reviewed with pressure sores in the sample of 3 who met the criteria for pressure sores. This also affected 1 of 3 supplemental sampled residents reviewed for pressure sores. (Resident #62, #100) Findings include: 1. The clinical record of Resident #62 was reviewed on 3/4/11 at 10:14 a.m. The resident was admitted to the facility on 8/8/06. The care plan for, Potential for skin breakdown, dated 7/16/09, and updated through 2/11/11, indicated the resident was "up ad lib with RW" (up as desired with rolling walker). Nurses notes indicated the resident sustained a fall with fracture of the right leg and returned from the hospital on 2/9/11. The nursing readmission assessment, dated, 2/9/11, indicated the resident had a "red 1 in (inch) circular area (R) (right) buttock" when she returned from the hospital. A treatment order of Zinc oxide to the buttocks was obtained at	F0279	F279 483.20(d), 483.20(k) (1)DEVELOP COMPREHENSIVE CARE PLANSI.Residents #100 has no pressure ulcers and has an updated care plan related to pressure ulcer prevention. Resident #62 has updated care plans related to pressure ulcer treatment and prevention.II.The facility has updated the care plans of all residents in regards to pressure sore treatment and prevention.III.The systemic change is that care planning will be completed by the nursing staff upon admission and with any significant change regarding pressure sore treatment and prevention. In addition, the weekly interdisciplinary "At Risk Meeting" will include a review of the care plans of new admissions, readmissions and residents with significant change regarding pressure sore treatment and prevention. Education was offered to the nursing staff on care planning in regards to pressure sore treatment and prevention.IV.The Unit Managers or designee will audit the charts of all new admissions, readmissions and those who have significant change for care plans and/or updates regarding pressure sore treatment and prevention 5 days a week at the daily stand up meeting for 12 months.The results will be discussed in the facility monthly Quality Assurance	04/03/2011

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	the time of readmission. The nursing readmission assessment, dated 2/9/11, indicated the resident was non-weight bearing on the right leg related to the fracture. The care plan for potential for skin breakdown was not changed at the time of readmission. On 2/11/11, Hydrocodone 7.5/325 (pain medication) was ordered for the resident as well as an ace wrap from the right foot to the thigh related to pain and edema. On 2/17/11, the pain medication was ordered to be given four times daily routinely. On 2/18/11, at 12:35 (no a.m. or p.m. indicated) nurses notes indicated the resident had an "Area noted to (L) (left) inner buttock 1.7 x (by) 0.6 x < (less than) 0.1. Full layer of skin missing. Area has scant amt (amount) of drainage. Wound bed red, periwound is pink. [No] pain noted [with] assessment. Res (resident) has recent fx (fracture) and is now dependent on staff for transfers, T & R (turning and repositioning); and toileting. Fx (fracture) of (R) femur prevents T & R to multiple sides. Staff aware of intervention."		Committee meeting and the frequency and duration will be adjusted as needed.	

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	A "Weekly Wound Evaluation Flow Record," dated 2/18/11, indicated the resident had a stage 2 pressure ulcer on the inner left buttock. On 2/18/11, a care plan was initiated for, "Resident has a pressure ulcer R/T (related to) recent fx; immobility. . ." Documentation of change in the plan of care was lacking until after the resident developed a pressure area. On 3/4/11 at 12:00 noon, the DoN (Director of Nurses) indicated she talked to the nurse who completed the readmission assessment when Resident #62 returned, after the fracture, and the nurse indicated the area on her right buttock resolved right after the zinc oxide was applied.			

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F0279 SS=D	2. The clinical record of Resident #100 was reviewed on 3/3/11 at 3 P.M. and indicated an admission assessment on 9/27/10. There was a pressure ulcer Resident Assessment Protocol [RAP] which indicated: "Resident is at risk for pressure ulcers R/T [related to] impaired mobility and incontinence. She is up with 2 assist T & R [turning and repositioning] per 2 assist and use of 1/2 SR's [one-half side rails]. Pressure relieving mattress on bed and cushion in w/c [wheel chair]. Daily skin checks. Skin intact. Ext [extensive] assist of 2 for toileting and pericare. No pressure ulcer on admission. The Admission Skin at Risk Assessment indicated on the 9/15/10 assessment, the resident had the potential for increase in friction and shearing. The Weekly Wound Evaluation Record indicated the resident was found with suspected deep tissue injuries on both heels on 10/4/10. An evaluation on 10/6/10 indicated the areas to the bilateral heels were due to the resident digging her feet into the bed. An air mattress was	F0279	F279 483.20(d), 483.20(k) (1)DEVELOP COMPREHENSIVE CARE PLANSI.Residents #100 has no pressure ulcers and has an updated care plan related to pressure ulcer prevention. Resident #62 has updated care plans related to pressure ulcer treatment and prevention.II.The facility has updated the care plans of all residents in regards to pressure sore treatment and prevention.III.The systemic change is that care planning will be completed by the nursing staff upon admission and with any significant change regarding pressure sore treatment and prevention. In addition, the weekly interdisciplinary "At Risk Meeting" will include a review of the care plans of new admissions, readmissions and residents with significant change regarding pressure sore treatment and prevention. Education was offered to the nursing staff on care planning in regards to pressure sore treatment and prevention.IV.The Unit Managers or designee will audit the charts of all new admissions, readmissions and those who have significant change for care plans and/or updates regarding pressure sore treatment and prevention 5 days a week at the daily stand up meeting for 12 months.The results will be discussed in the facility monthly Quality Assurance	04/03/2011

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	applied to the bed and padding was added to the w/c pedals. A request for the care plan prior to the development of the pressure ulcers was made on 3/3/11 at 9 A.M. Interview with DoN indicated the care plan provided was for pressure ulcers from the point of the resident's admission. Review of the care plan indicated it was undated and was for the problem, "Potential for skin breakdown related to pressure areas bilat [bilateral] heels." On 10/20/10 "l [left] heel" was added. Interventions were handwritten, but it was unknown on what date, to include: Float heels while abed Enc [encourage] res to get oob [out of bed] as much as possible tx [treatment] as ordered Vit C [vitamin C] et [and] Zinc sulfate for wound healing notify MD [medical doctor]and family prn [as needed] air mattress padded w/c pedals continue foam dressing to right heel x 30 days for protection (area healed). Nurses notes provided by the DoN at 4:52 P.M. on 3/3/11 indicated on 10/4/10, "Staff nurse et [and] CNA called this nurse to look at bil		Committee meeting and the frequency and duration will be adjusted as needed.	

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	[bilateral] heels. Resd [resident] in bed, heels on bed. Lt [left] heel c [with] 2.5 x 2.2 purple, dark red, fluid filled blister intact. Rt [right] heel dark red nonblanching 2.6 x 3 mushy c [two] dark spots 0.1 x 0.1. Placed pillow under bil legs to get heels off bed." **3.1-35(a)**			

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F0309 SS=D	Based on observation, interview and record review, the facility failed to ensure pain management was provided for 1 of 3 residents reviewed for pressure ulcers in a sample of 3 who met the criteria for pressure ulcer treatment [Resident #113], and for 2 of 3 residents who met the criteria for pain recognition and management in a stage 1 sample of 20. [Residents #29 and 74] Findings include: 1. During observation on 3/3/11 at 9 A.M., Resident #113 was taken to therapy for treatment to a pressure area. The clinical record of Resident #113 was reviewed on 3/3/11 at 8:30 A.M., and indicated nurses notes dated 1/22/11 at 0230 [2:30 A.M.] "Res [resident] tearful when staff changes res q [every] 2 hours & repositions her or does any other care. Incont B & B [incontinent of bowel and bladder]. Found area on right buttock/hip area. Measures 5 CM [centimeter] x 5 CM reddened line, .5 cm width, 0 depth, & another 5 cm x 5 cm .5 cm width c [with] small scabs & reddened. Underneath the area is hard, approx [approximately]. 7 cm x 9 cm rounded. Res claims no pain. No distress s/s [signs or symptoms] observed." There was a physician's order dated 3/2/11, which indicated "PT [physical therapy] treatment. Sharp debridement as needed to R [right] hip. Dressing change clean c [with]	F0309	F309 483.25PROVIDE CARE/SERVICES FOR HIGHEST WELL BEINGI.Residents #113, #29 and #74 have updated pain assessments and pain management programs. In addition, the as needed pain medication is being documented per facility policy. II.The facility has updated all resident's pain assessments and pain management programs have been put into place where applicable. PRN pain medication is being documented per facility policy.III.The systemic change includes that the 24 hour report sheets and all new medication orders will be reviewed in the daily (5 days a week) clinical meeting by the interdisciplinary team. The chart of any resident with new complaints of pain, change in pain or new pain medication orders will be reviewed for an appropriate pain assessment, pain management program and documentation of administration of pain medications. Nurses will be provided education on this systemic change, as well as pain assessment and management.IV.The Director of Nursing or her designee will monitor a minimum of 10 prn pain flow sheets for non-medicinal intervention prior to and pain assessment prior to and after medication administration weekly	04/03/2011

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	wound cleaner. packing wound c [with] wet gauze. Then secured c hydrochloride." A physician's order dated 2/16/11, indicated "PT to eval et [evaluate and] treat unstageable wound to R [right] hip." The 2/16/11 PT evaluation indicated, "will be seen 5xwk [five times a week] for wound care r hip tx [right hip treatment] diathermy x 20 minutes to r hip; clean - wound cleanser -apply santyl ointment, then hydrocolloid." Observation of care on 3/3/11 at 9:43 A.M., indicated PT #1 had the diathermy (deep heat therapy to increase circulation to an area) in place on the resident's right ischial pressure ulcer The resident was lying on her left side. The wound was 2 cm diameter and 1 cm deep, and there was redness surrounding the wound extending out 5 cm in diameter. PT #1 indicated the wound had just had developed depth this week following the debridement. The resident cried out in pain during the treatment whenever the wound was touched by the therapist. Interview with PT #1 following the treatment indicated she had not packed the wound with gauze as ordered because it had caused so much pain to the resident the previous day. Interview with the charge nurse caring for the resident, LPN #1, on 3/3/11 at 10:15 A.M. indicated the resident had not been pre-medicated prior to the treatment. She said that ever since the resident came to the facility a year ago, she had cried all the time		for 4 weeks. The audit will then proceed to a minimum of 10 flow sheets monthly for an additional 11 months. The Director of Nursing or her designee will review the pain assessments and pain management programs for at least 5 residents with new or increased pain weekly for 4 weeks and then 5 residents monthly for 11 months to monitor effectiveness. The Therapy Supervisor will monitor a minimum of 2 dressing changes provided by therapy weekly for 4 weeks then 2 dressing changes per month for a total of 12 months to observe for any pain issues.	

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	like she was in pain. "Even before we touched her, she cried." LPN #1 was told the resident cried out in pain during the treatment and the therapist did not follow the doctor's orders of packing the wound because the resident was in pain. Interview with the DoN on 3/3/11 at 2:20 P.M. indicated LPN #1 gave the resident the prn [as needed] Vicodin, waited an hour, then provided the treatment with the wet gauze as ordered. The DoN indicated the resident had not experienced pain before the debridement of yesterday. That was why they had not pre-medicated, but there was an order added to medicate the resident prior to pressure ulcer treatment today.			

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F0309 SS=D	2. The clinical record of Resident #29 was reviewed on 3/3/11 at 9:55 a.m. The resident's diagnoses included, but were not limited to, chronic pain, general debility, total knee replacement, and acute left arm weakness. The physician's recapitulation of orders, signed on 2/24/11, included, but were not limited to, the following: Tylenol Extra Strength (pain medication) 500 mg (milligrams) - Take 1 tablet po (by mouth) Bid (twice daily) Ultram (pain medication) 50 mg 1 po bid routinely Additional PRN (as needed) orders included: Tylenol 325 mg - Take 2 tabs (650 mg) po q (every) 4 hrs as needed for pain or elevated temp Ultram 50 mg - Take 1 tab po q 6 hrs as needed for pain The physician's progress note, dated 2/24/11, indicated the resident had a recent shoulder x-ray which showed degenerative joint disease. Nurses notes indicated the resident had the x-ray completed related to complaints of pain in her shoulder on 2/15/11 at 1:00 p.m.	F0309	F309 483.25PROVIDE CARE/SERVICES FOR HIGHEST WELL BEINGI.Residents #113, #29 and #74 have updated pain assessments and pain management programs. In addition, the as needed pain medication is being documented per facility policy. II.The facility has updated all resident's pain assessments and pain management programs have been put into place where applicable. PRN pain medication is being documented per facility policy.III.The systemic change includes that the 24 hour report sheets and all new medication orders will be reviewed in the daily (5 days a week) clinical meeting by the interdisciplinary team. The chart of any resident with new complaints of pain, change in pain or new pain medication orders will be reviewed for an appropriate pain assessment, pain management program and documentation of administration of pain medications. Nurses will be provided education on this systemic change, as well as pain assessment and management.IV.The Director of Nursing or her designee will monitor a minimum of 10 prn pain flow sheets for non-medicinal intervention prior to and pain assessment prior to and after medication administration weekly	04/03/2011

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	A physician's progress note, dated 9/9/10, indicated the resident had back pain which seemed to be arthritic in nature. A physician's progress note on 7/15/10 indicated the resident complained of left knee pain with osteoarthritis and knee pain. The note indicated the resident received 80 mg Depomedrol (steroid injection) in the left knee. The care plan, dated 3/1/11, indicated the resident had complaints of chronic pain related to morbid obesity, general debility, and impaired mobility with a goal for the resident to have effective pain relief as evidenced by pain assessment quarterly/prn and daily pain rating per MAR (medication administration record). Interventions included the following: Monitor and record any complaints of pain: location, duration, quantity, quality, alleviating factors, aggravating factors. Use pain relief measures: distraction, relaxation, massage, TV. Monitor effectiveness Administer medications as ordered 1/2 SR's (siderails) and trapeze bar as enablers Therapy as ordered Monitor and record any non-verbal		for 4 weeks. The audit will then proceed to a minimum of 10 flow sheets monthly for an additional 11 months. The Director of Nursing or her designee will review the pain assessments and pain management programs for at least 5 residents with new or increased pain weekly for 4 weeks and then 5 residents monthly for 11 months to monitor effectiveness. The Therapy Supervisor will monitor a minimum of 2 dressing changes provided by therapy weekly for 4 weeks then 2 dressing changes per month for a total of 12 months to observe for any pain issues.	

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	signs of pain: (e.g., guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.) Refer to physical therapy for muscle strengthening, toning, body mechanics, and positioning. Pain assessment quarterly and prn. The February 2011 MAR indicated Tylenol 2 tablets were administered on 2/7/11 at 3:30 p.m. The "Nurse's Medication Notes," used to document the medication given and response was marked off with instructions to, "use PRN (as needed) monitoring form." The "PRN Pain Assessment Monitoring Form" lacked documentation of the administration of the pain medication on 2/7/11, including the non-medication intervention attempted prior to administration of the medication and the response to the medication, and the information was lacking in the nurses notes. Nurses notes on 2/15/11 at 1:00 p.m. indicated the resident was complaining of right shoulder pain and the physician was notified and a new order was obtained on 2/16/11 for an x-ray of the shoulder. Documentation of a complete assessment of the pain was lacking on 2/15/11.			

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On 3/3/11 at 4:00 p.m., the lack of documentation of assessment of pain and response to treatment was discussed with the DoN (Director of Nurses). She indicated she was unable to locate any additional information for review.

3. The clinical record of Resident #74 was reviewed on 3/3/11 at 3:05 p.m. The resident's diagnoses, included but were not limited to, Chronic Pain Syndrome.

The resident had been receiving the following pain medications:
11/10/10 - Tylenol Extra Strength 500 mg (milligrams) 1 po (by mouth) qid (four times daily)
Tylenol 325 mg 2 po q (every) 4 hrs (hours) as needed for pain or elevated temp > (greater than) 100

A physician's progress note, dated 2/18/11, indicated the resident had severe arthritis; "I asked if wants anything else, 'No I'm afraid of taking too much medicine.'"

A care plan, dated 2/28/11, indicated, "Resident has increased risk of having chronic pain diagnosis of chronic pain syndrome," with a goal

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	for the resident to verbalize pain is at manageable levels as evidenced by the pain scale. Interventions including the following: Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors; Monitor and record any non-verbal signs of pain; (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.).; Use non-medicated pain relief measures: massage, physical therapy, stretching and strengthening exercises, repositioning, etc. Monitor effectiveness; Administer medications: Tylenol, vitamin B. Monitor and record effectiveness. Report adverse side effects.; Position for comfort; therapy screen quarterly and prn; Evaluate effectiveness of pain management interventions. Adjust if ineffective or adverse side effects emerge; Stand-up lift with 2 assist; Contact MD/family prn The January 2011 MAR indicated Tylenol 2 (650 mg) was given on 1/13/11 at 10:00 p.m. There was no assessment of the pain, including			

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	location, severity, and effect on the resident, documentation of non-pharmacological interventions attempted prior to medication administration or effectiveness of the intervention documented on the MAR and the "Pain Flow Sheet" for January 2011 was blank. On 3/3/11 at 4:00 p.m., the lack of documentation of assessment of pain and response to treatment was discussed with the DoN (Director of Nurses). She indicated she was unable to locate any additional information for review. **4. The "Pain Management Program" policy, dated 3/10, was provided for review on 3/3/11 at 4:00 p.m. The policy included, but was not limited to, the following:** **"PRN Pain Medication-** **When analgesics are administered in response to an episode of pain, nurses must document their assessment, treatment, and the effectiveness of the treatment on the PRN pain assessment monitoring form.** **The form requires documentation**			

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	of the following information: **1. Pain assessment and treatment** *** Date and time** *** Site of pain** *** Non-pharmacological treatments provided** *** Source of information-family/resident/assessment(perceived pain)** *** Pain type** *** Pain medication given** *** Level of sedation** *** Pain rating 0-10** **2. Effectiveness of treatment** *** Side effects** *** Response (30-60 min. after medication administration)- pain rating** *** Action successful** *** Initials** **3.1-37(a)**			

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F0314 SS=D	Based on observation, interview, and record review, the facility failed to provide treatment to prevent infection and promote healing for 2 of 3 residents reviewed for pressure ulcers in a sample of 3 who met the criteria for pressure sores [Residents #113 and 55]; and failed to prevent the development of pressure ulcers for 1 of 3 residents reviewed for pressure ulcers who met the criteria for incidence or worsening of pressure ulcers in a sample of 3 [Resident #100], and 1 of 3 residents in a supplemental sample of 3 residents reviewed for pressure ulcers [Resident #62]. Findings include: 1. During observation on 3/3/11 at 8:12 A.M., Resident #113 being wheeled from breakfast in the MDR and was placed just outside the door to her room. The resident was taken to physical therapy for pressure ulcer treatment at 9 A.M. The clinical record of Resident #113 was reviewed on 3/3/11 at 8:30 A.M., and indicated the resident was admitted to the facility 3/25/10 following hospitalization for an acute heart attack. Other diagnoses	F0314	F314 483.25(c)TREATMENT/SCVS TO PREVENT/HEAL PRESSURE SORESI.Resident #55 no longer resides at the facility. Resident #62 and #113 have an updated plan of care for pressure ulcer treatment and prevention. Resident #113 has an updated assessment of the wound. Resident #100 does not have any pressure ulcers and has an updated prevention of pressure ulcer care plan.II.The facility has completed new Skin At Risk assessments for all residents and updated the care plans for those residents at risk for skin breakdown. All current residents with pressure ulcers have an updated assessment of the wound prior to any treatment changes. All current treatments to pressure ulcers are being conducted in a manner to prevent infection and promote healing.III.The systemic change is that the wound nurse will assess and document weekly on all pressure areas being treated by therapy. In addition, 5 days a week nurse management will review the 24 hour report books for new or worsening pressure ulcers and new treatment orders and audit the appropriate chart for proper assessment of the wound. All dressing changes are now being conducted in the resident's room. Nursing education has been provided	04/03/2011

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	included, but not inclusive were moderate dementia, hypertension, DJD [degenerative joint disease], COPD [chronic obstructive pulmonary disease], hypothyroidism and anxiety. The resident had been living at home before prior to the hospitalization. Nurses notes dated 1/22/11, at 0230 [2:30 A.M.] indicated, "Res [resident] tearful when staff changes res q [every] 2 hours & repositions her or does any other care. Incont B & B [incontinent of bowel and bladder]. Found area on right buttock/hip area. Measures 5 CM [centimeters] x 5 CM reddened line, .5 cm width, 0 depth, & another 5 cm x 5 cm .5 cm width c [with] small scabs & reddened. Underneath the area is hard, approx. 7 cm x 9 cm rounded. Res claims no pain. No distress s/s [signs or symptoms] observed." Observation of care of the pressure ulcer on 3/3/11 at 9:43 A.M., indicated physical therapy was to perform the treatment. Physical therapist [PT] #1 indicated diathermy (deep heat therapy to increase circulation to an area) was in place. The resident was lying on her left side in a bed. There was an incontinent brief rolled under the resident and visible brown		regarding documentation of assessment, treatment and appropriate infection control during wound care. Therapy has been provided education on communicating any changes in wounds to nursing as well as wound treatment and assessment. Education for licensed nurses included care planning, prevention, treatment and assessment of pressure areas.IV.The Unit Managers or their designee will audit the charts of all new residents, readmissions, and residents with significant change for care plans and/or care plan updates regarding pressure sore treatment and prevention 5 days a week at the daily clinical meeting for 12 months. Wound care documentation, with emphasis on changes, assessment and treatment will be audited weekly per nursing administration for 12 months.The Director of Nursing or her designee will audit a minimum of 3 dressing changes for proper assessment, treatment and infection control technique weekly for 4 weeks, then a minimum of 3 monthly for 4 months, then one time a month for a total of 12 months of monitoring. The Therapy Supervisor will observe 2 dressing changes weekly for 4 weeks for proper assessment, treatment and infection control techniques. The audit will then	

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	smearing was on the brief. The wound was on the right ischium and had depth. PT#1 indicated the wound just opened up after debridement the current week and indicated the wound was 1 cm deep. The wound was round with a 2 cm diameter. There was redness surrounding the wound extending 5 cm the diameter of the wound. The woundbed had tan, loose tissue that moved around when cleansed. PT #1 indicated the therapy department told the staff upstairs that the resident needed cleaned before she came down for treatment, but she continues to come to therapy with feces in her brief. The resident had been sent to therapy with feces in her brief the previous day, also. PT #1 continued on with the treatment of the open wound with the feces on the incontinent brief in the immediate area of the wound. The resident was transferred back upstairs with soiled brief in place at 10 A.M. Interview with PT #1 at 10 A.M. on 3/3/11 indicated she was aware that		continue for a minimum of 2 dressing changes a month for 11 months.The results of the audits will be reviewed in the facility monthly Quality Assurance Committee meeting and the frequency and duration will be adjusted after review.	

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	treatment should not be done with feces in the area, but that was the way the resident was sent for treatment. PT #1 indicated she staged the wound as a Stage 3. Interview with the charge nurse, LPN #1, caring for Resident #113 at 10:08 A.M. on 3/3/11 indicated she had not been told the resident had ever been sent to therapy with an incontinent episode. She had assisted staff in cleaning the resident of feces before breakfast. Interview with LPN #1 at the time indicated the physician was aware of the redness surrounding the wound, but did not not know if the resident had been seen by the physician Interview with the DoN on 3/3/11 at 2:20 P.M. indicated she and the wound care nurse had just talked about the resident's wound assessment. Starting next Monday, the wound care nurse will be assessing the wound with therapy. The last time the wound care nurse had seen the wound was on February 21, 2011. The DoN indicated that once therapy picked up a resident for treatment, they did the assessments.			

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	The facility's policy "SKIN CARE AND PRESSURE/NON-PRESSURE ULCER PREVENTION AND MANAGEMENT PROGRAM," provided at 3/4/11 at 7:50 A.M. and reviewed at 9 A.M., indicated "Skin Care and Early Treatment, Protection, Protect skin from exudates, perspiration, and incontinence." "PRESSURE ULCER TREATMENT, Wound Assessment and Documentation: When assessing a wound and documenting findings, include the following factors: Pain, tenderness or warmth to touch may indicate infection." 2. The clinical record of Resident #100 was reviewed on 3/3/11 at 3 P.M. and indicated the resident had no pressure ulcer on admission in September 2010. The admission assessment indicated the resident was at risk for pressure areas, but had no pressure areas. The 12/16/10 quarterly assessment indicated the resident was at risk for pressure areas, but had no pressure ulcers. The Weekly Wound Evaluation Record indicated:			

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	Left Heel 10/4/10 SDTI [Suspected Deep Tissue Injury] 2.5 x [by] 2.2 cm [centimeter] x <.1 cm depth 10/11/10 unstageable 2..2 x 2.2 10/18/10 unstageable 2.3 x 2.7 10/25/10 2.2 x 2.7 11/1/10 unstageable 2.2 x 2.1 11/8/10 sdti 2.2 x 1.4 11/15/10 1.8 x 1.6 11/22/10 .5 x 1.1 Stage 2 11/29/10 .6 x .4 stage 2 12/6/10 healed Right Heel 10/4/10 2.6 x 3 sdti 10/11/10 unstageable .3 x. 3 10/19 healed The facility obtained physician's orders for Vitamin C and Zinc for 30 days and foam dressing to bilateral heels, change q [every] 7 days on 10/4/10. Additional orders were received on 10/13/10 to continue physical therapy including there ex [therapeutic exercise], neuro [neurological re-training], and gait training for 3 x wk x 2 wks [three times a week for two weeks]. The Weekly Wound Evaluation Record indicated on 10/6/10, areas to			

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	bilateral heels. "Resd [resident] digs feet into bed, air mattress applied, also has padded w/c pedals & OT [occupational therapy] is to assessing if w/c [wheelchair] pedals can be removed." Observation 3/3/11 at 1:30 P.M. indicated there was a trapeze on the bed, pressure reduction mattress on bed, and cushions in the w/c and on the foot pedals. Interview with the DoN at 2 P.M. on 3/4/11 indicated the resident had developed the heel wounds and was evaluated, and it had been determined the wounds were due to the resident digging her heels into the mattress. She stated the resident had not been observed to do so prior to the evaluation.			

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F0314 SS=D	3. On 3/1/11 at 3:18 p.m., the LPN (Licensed Practical Nurse) caring for Resident #55, indicated the resident had a Stage 3 pressure ulcer on her coccyx. On 3/3/11 at 10:00 a.m., LPN #3 was observed to complete the treatment for Resident #55's pressure ulcer. When the hydrocolloid dressing was removed by the nurse, the area on the coccyx measured approximately 3 centimeters (cm) by 2 centimeters and was black in color with several smaller, red, open areas around the perimeter of the wound. All areas were cleaned with normal saline and a clean hydrocolloid dressing was replaced over the wound. The clinical record of Resident #55 was reviewed on 3/3/11 at 11:15 a.m. The resident's diagnoses included, but were not limited to, Stroke, Cerebrovascular Disease, and Atrial Fibrillation. A physician's order, dated 3/3/11 at 10:20 a.m., indicated the following: Discontinue previous treatment to coccyx. Clean with normal saline, apply Santyl (debriding agent) to coccyx wound bed only and cover	F0314	F314 483.25(c)TREATMENT/SCVS TO PREVENT/HEAL PRESSURE SORESI.Resident #55 no longer resides at the facility. Resident #62 and #113 have an updated plan of care for pressure ulcer treatment and prevention. Resident #113 has an updated assessment of the wound. Resident #100 does not have any pressure ulcers and has an updated prevention of pressure ulcer care plan.II.The facility has completed new Skin At Risk assessments for all residents and updated the care plans for those residents at risk for skin breakdown. All current residents with pressure ulcers have an updated assessment of the wound prior to any treatment changes. All current treatments to pressure ulcers are being conducted in a manner to prevent infection and promote healing.III.The systemic change is that the wound nurse will assess and document weekly on all pressure areas being treated by therapy. In addition, 5 days a week nurse management will review the 24 hour report books for new or worsening pressure ulcers and new treatment orders and audit the appropriate chart for proper assessment of the wound. All dressing changes are now being conducted in the resident's room. Nursing education has been provided	04/03/2011

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	with adhesive foam dressing every day and as needed for soiling or dislodgement. There was no documentation of an assessment of the wound in the nurses notes at the time the new treatment was obtained from the physician on 3/3/11. The last documentation of an assessment of the wound was on the "Weekly Wound Evaluation Flow Record," and was dated 2/28/11. This assessment indicated the wound measured 1.9 cm (centimeters) by 08. cm, without depth indicated. The assessment indicated the wound was Stage 3 and the wound bed was yellow with pink noted around the wound and yellow drainage noted. On 3/4/11 at 9:50 a.m. the DoN (Director of Nurses) was interviewed regarding the lack of an assessment regarding wound prior to changing the treatment on 3/3/11 and the presence of additional red, open areas around the blackened pressure sore during observation of the treatment. She indicated the treatment change came as a result of conversation with hospice on Monday after the Wound Nurse discussed the condition of the wound with hospice after doing the		regarding documentation of assessment, treatment and appropriate infection control during wound care. Therapy has been provided education on communicating any changes in wounds to nursing as well as wound treatment and assessment. Education for licensed nurses included care planning, prevention, treatment and assessment of pressure areas.IV.The Unit Managers or their designee will audit the charts of all new residents, readmissions, and residents with significant change for care plans and/or care plan updates regarding pressure sore treatment and prevention 5 days a week at the daily clinical meeting for 12 months. Wound care documentation, with emphasis on changes, assessment and treatment will be audited weekly per nursing administration for 12 months.The Director of Nursing or her designee will audit a minimum of 3 dressing changes for proper assessment, treatment and infection control technique weekly for 4 weeks, then a minimum of 3 monthly for 4 months, then one time a month for a total of 12 months of monitoring. The Therapy Supervisor will observe 2 dressing changes weekly for 4 weeks for proper assessment, treatment and infection control techniques. The audit will then	

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	treatment. She indicated hospice hadn't gotten a change in treatment before yesterday. At approximately 10:15 a.m., the DON indicated she talked with the Wound Nurse, and she didn't document her conversation with hospice on Monday. 4. The clinical record of Resident #62 was reviewed on 3/4/11 at 10:14 a.m. The resident was admitted to the facility on 8/8/06. The care plan for, Potential for skin breakdown, dated 7/16/09, and updated through 2/11/11, indicated the resident was "up ad lib with RW" (up as desired with rolling walker). Nurses notes indicated the resident sustained a fall with fracture of the right leg and returned from the hospital on 2/9/11. The nursing readmission assessment, dated, 2/9/11, indicated the resident had a "red 1 in (inch) circular area (R) (right) buttock" when she returned from the hospital. A treatment order of Zinc oxide to the buttocks was obtained at the time of readmission. The nursing readmission assessment, dated 2/9/11, indicated the resident was non-weight bearing on the right leg related to the fracture. The care		continue for a minimum of 2 dressing changes a month for 11 months.The results of the audits will be reviewed in the facility monthly Quality Assurance Committee meeting and the frequency and duration will be adjusted after review.	

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	plan for potential for skin breakdown was not changed at the time of readmission. On 2/11/11, Hydrocodone 7.5/325 (pain medication) was ordered for the resident as well as an ace wrap from the right foot to the thigh related to pain and edema. On 2/17/11, the pain medication was ordered to be given four times daily routinely. On 2/18/11, at 12:35 (no a.m. or p.m. indicated) nurses notes indicated the resident had an "Area noted to (L) (left) inner buttock 1.7 x (by) 0.6 x < (less than) 0.1. Full layer of skin missing. Area has scant amt (amount) of drainage. Wound bed red, periwound is pink. [No] pain noted [with] assessment. Res (resident) has recent fx (fracture) and is now dependent on staff for transfers, T & R (turning and repositioning); and toileting. Fx (fracture) of (R) femur prevents T & R to multiple sides. Staff aware of intervention." A "Weekly Wound Evaluation Flow Record," dated 2/18/11, indicated the resident had a stage 2 pressure ulcer on the inner left buttock. On 2/18/11, a care plan was initiated			

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	for, "Resident has a pressure ulcer R/T (related to) recent fx; immobility. . ." Documentation of change in the plan of care was lacking until after the resident developed a pressure area. On 3/4/11 at 12:00 noon, the DoN (Director of Nurses) indicated she talked to the nurse who completed the readmission assessment when Resident #62 returned, after the fracture, and the nurse indicated the area on her right buttock resolved right after the zinc oxide was applied. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0329 SS=D	Based on record review and interview, the facility failed to monitor 2 of 10 residents, in a sample of 10 residents reviewed who met the criteria for unnecessary medications, for monitoring of blood pressure medication (Resident # 42) and unnecessary use of a mood stabilizing medication (Resident #54). **Findings include:** The clinical record for Resident # 42 was reviewed on 3/3/11 at 2:45 p.m. The resident had diagnoses which included, but were not limited to: high blood pressure, weakness, coronary artery disease, gastro-esophogeal reflux disease, depression, heart failure, osteopenia, right ulna fracture, anxiety, basal cell carcinoma, and atypical psychosis. The physician telephone orders, dated 2/26/11, increased the blood pressure lowering medication, Imdur, from 20 milligrams to 30 milligrams each day. The order indicated it was changed to the higher dose to lower a rapid pulse rate. In addition, the resident was receiving a Nitro-patch at the rate of 0.4 micrograms per hour and propanolol 10 milligrams twice daily. All of these medications were	F0329	F329 483.25(l)DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGSI.The blood pressure and pulse of resident #42 was monitored 6 times between 2/28/11 and 3/4/11 and was documented in the computerized Matrix Documentation System utilized by the facility. A gradual dose reduction was completed for resident #54.II.The facility has reviewed all residents on psychoactive medications for gradual dose reductions and addressed as needed. All residents receiving blood pressure medication have their blood pressure monitored at least weekly.III.The systemic change is that monthly reviews of gradual dose reductions will occur between the consultant pharmacist, social services and nursing. The systemic change also includes adding residents who have changes in blood pressure medications to acute charting to monitor their blood pressure per policy. Social Services has initiated a gradual dose reduction tracking tool. Social Services and nursing staff have been provided education regarding gradual dose reduction. Nursing staff was provided education in blood pressure and pulse monitoring after medication changes that affect blood pressure and/or pulse.IV.The Director of Nursing or her designee will monitor by	04/03/2011

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	used to lower the blood pressure. Both propanolol and Imdur lower the pulse rate as well. The nursing notes, treatment record, and medication record for February, 2011 and March, 2011 were reviewed. There was no blood pressures or pulses recorded for the resident from the time of the order through the end of the survey on 3/4/11. **The Director of Nursing was interviewed on 3/3/11 at 3:30 p.m. She indicated the blood pressure and pulse should have been checked with the dosage change of the medication.**		reviewing all orders for a change in blood pressure medication and reviewing for appropriate monitoring of vital signs 5 days a week. An audit for appropriate monitoring of blood pressure medication will occur for a minimum of 10 residents receiving these medications weekly for 4 weeks and then 10 residents monthly for a total duration of 12 months. The facility will audit 100% of the residents receiving psychoactive medications for gradual dose reduction and then review monthly thereafter.The results of this audit will be reviewed in the facility monthly Quality Assurance Committee meeting and the duration and frequency of the audits adjusted after review.	

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F0329 SS=D	2. A clinical record review was done on 3/2/11 at 2 p.m. for Resident #54 and included the following: Annual MDS (minimum data set) diagnoses included but not limited to Alzheimer's dementia with behavioral disturbance. A record titled "Psychiatric Evaluation dated 7/6/2009 indicated resident referred due to anxiety mood instability and ineffective participation in care. Staff reported she was yelling out with constant request, and that people were leaving the dining room due to her behaviors...Summary: In summary the patient is having problems with affective and cognitive concerns...Recommended: ...Therapy should be from cognitive-behavioral, insight oriented, and supportive perspectives. Mental status is not considered an impediment to therapy at this point. Medications appear to be generally appropriate, although the addition of a mood stabilizer may be beneficial. A physician order originally dated 7/6/2009 indicated Depakote 125 mg (milligram) BID (twice daily). A review of the clinical record from April 2010 to current did not have any documentation of behaviors present. The behavior flow record for the month of December 2010 to to March	F0329	F329 483.25(l)DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGSI.The blood pressure and pulse of resident #42 was monitored 6 times between 2/28/11 and 3/4/11 and was documented in the computerized Matrix Documentation System utilized by the facility. A gradual dose reduction was completed for resident #54.II.The facility has reviewed all residents on psychoactive medications for gradual dose reductions and addressed as needed. All residents receiving blood pressure medication have their blood pressure monitored at least weekly.III.The systemic change is that monthly reviews of gradual dose reductions will occur between the consultant pharmacist, social services and nursing. The systemic change also includes adding residents who have changes in blood pressure medications to acute charting to monitor their blood pressure per policy. Social Services has initiated a gradual dose reduction tracking tool. Social Services and nursing staff have been provided education regarding gradual dose reduction. Nursing staff was provided education in blood pressure and pulse monitoring after medication changes that affect blood pressure and/or pulse.IV.The Director of Nursing or her designee will monitor by	04/03/2011

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	2011 indicated no behaviors. The behavior management team review dated Dec 2010 indicated no behaviors. A current care plan in clinical record indicated..."Review medications for possible dose reduction at least every 6 months..." During an interview with the social service director on 3/3/11 at 8:50 a.m. she indicated the resident has not displayed any behaviors in the last month or two and has been on medications and is monitored thru the behavior program. The social service was unable to locate when the resident last showed behavioral symptoms or when the last GDR (gradual dose reduction) of Depakote was attempted and/or contraindicated. During an interview with the DNS on 3/3/2011 at 3:50 p.m.. she indicated she was unable to locate any reason or documentation for why GDR for Depakote has not been attempted for Resident #54 in the absence of behaviors. 3.1-48(a)(2)		reviewing all orders for a change in blood pressure medication and reviewing for appropriate monitoring of vital signs 5 days a week. An audit for appropriate monitoring of blood pressure medication will occur for a minimum of 10 residents receiving these medications weekly for 4 weeks and then 10 residents monthly for a total duration of 12 months. The facility will audit 100% of the residents receiving psychoactive medications for gradual dose reduction and then review monthly thereafter.The results of this audit will be reviewed in the facility monthly Quality Assurance Committee meeting and the duration and frequency of the audits adjusted after review.	

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F0356 SS=C	Based on observation and interview, the facility failed to ensure total nursing hours were posted on a daily basis. This was observed on 2 of 4 days and had the potential to affect 100 of 100 residents residing in the facility. (3/1/11 and 3/3/11). In addition, the facility failed to ensure the nursing staffing posting contained the total actual hours worked for licensed and unlicensed staff on 4 of 4 survey days (3/1, 3/2, 3/3, and 3/4/11). Findings include: During the initial tour of the facility on 3/1/11 at 9:05 a.m., the nursing staffing posting on the 100/300 units was for the night shift only and was dated 2/28/11. On 3/3/11 at 7:55 a.m., upon entry to the facility, nursing staffing posting at the 100/300 units was completed only for the night shift and remained this way at 4:15 p.m. on 3/3/11. The nursing staff posting did not contain the total actual hours worked for licensed or unlicensed nursing staff on any day of the survey, 3/1, 3/2, 3/3, and 3/4/11 upon entry to the facility at 8:00 a.m. each day.	F0356	F356 483.30(e)POSTED NURSE STAFFING INFORMATIONI.The facility is posting the correct staffing information, including the total nursing hours at the beginning of each shift.II.The facility will continue to post staffing information at the beginning of each shift, including the total nursing hours for each discipline.III.The systemic change is that the completion of the posting of nursing hours has been assigned to a specific nurse and is located in one central location. The nursing staff has also been provided education on the posting of nursing hours each shift, including posting the total hours.IV.The Director of Nursing or her designee will audit daily staffing sheets 5 times weekly for 4 weeks, weekly for one month and will continue the audit at least monthly for 10 months.The results will be discussed in the monthly facility Quality Assurance Committee meeting and the audit will be adjusted as needed.	04/03/2011

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	The Director of Nursing was interviewed on 3/4/11 at 2:15 p.m. concerning the posting of staffing information. She indicated the facility had posted the number of hours per nurse or CNA, not the total number of hours per staff description. **3.1-13(g)**			

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F0371 SS=E	Based on observation, record review, and interview, the facility failed to serve milk and milk products at a temperature to prevent foodborne bacteria growth. This had the potential to affect 58 of 58 residents served their meals in their rooms out of a total of 98 residents who received food from the kitchen. Findings include: During observation on 3/3/11 at 11 A.M., lunch service was beginning. The temperature of food products had been taken prior to tray preparation and indicated the milk was 41 degrees Fahrenheit [F]. Interview with the Certified Dietary Manager [CDM] during the observation indicated there were 58 residents who received trays in their rooms. A test tray was requested for the 300 hall room tray cart. The cart left the kitchen at 11:43 A.M. and arrived at the 300 hall at 11:44 A.M. Staff were present on the hall and started serving the trays from the cart at 11:46 A.M. The cart used to transport the food trays had no heating or cooling environment. The last tray was served to a resident	F0371	F371 483.35(i)FOOD PROCURE, STORE/PREPARE/SERVE-SANITARYI.The facility is now utilizing a drink cart for milk and insulated bowls for milk products, such as pudding.II.All milk products are currently being served at a temperature to prevent foodborne bacteria growth.III.The systemic change is that the facility is utilizing drink carts for milk. Milk products, such as pudding, are being served in insulated bowls and are taken out of refrigeration immediately prior to serving. Dietary staff were provided education regarding the system and the reason for keeping milk products at appropriate temperature.IV.The Certified Dietary Manager will randomly monitor the temperature of milk and milk products a minimum of 3 times weekly for 4 weeks, then 1 time a week for 4 months and monthly thereafter for a total of 12 months monitoring.The results of the audit will be reviewed at the facility monthly Quality Assurance Committee meeting and adjusted as needed.	04/03/2011

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	at 11:58 A.M. and the test tray was immediately taken to the nurses' pantry and tested for palatability and temperature with the CDM. The hot foods were hot, but the milk and pudding were not cold. The CDM took temperatures and the milk was 54 degrees F and the pudding was 50 degrees F. Interview with the CDM at the time indicated the pudding was not to be room temperature, but was to be served cold and had been taken out of the refrigerator just prior to service. Review of the Federal Drug Administration 2009 Food Code the following was noted at 3-501.16: "Potentially Hazardous Food. Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) or this section, POTENTIALLY HAZARDOUS FOOD(TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained: at 5 [degrees] C [Celsius] (41 degrees F) or less." 3.1-21(a)(2) 3.1-21(i)(3)			

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F0441 SS=D	Based on observation, record review, and interview, the facility failed to provide pressure ulcer treatment for 1 of 3 residents observed for infection control practices in a manner to promote healing and prevent infection in a sample of five direct care observations. [Resident #113] Findings include: 1. Observation of care of the pressure ulcer for Resident #113 on 3/3/11 at 9:43 A.M., indicated physical therapy was to perform the treatment. Physical therapist [PT] #1 indicated diathermy was in place. The resident was lying on her left side in a bed. There was an incontinent brief rolled under the resident and visible brown smearing was on the brief. The wound was on the right ischium and had depth. PT#1 indicated the wound just opened up after debridement the current week and indicated the wound was 1 cm deep. The wound was round with a 2 cm diameter. There was redness surrounding the wound extending 5 cm the diameter of the wound. The woundbed had tan, loose tissue that moved around when cleansed.	F0441	F 441 483.65INFECTION CONTROL, PREVENT SPREAD, LINENSI.Resident #113 was provided peri-care. The dressing was then completed. The therapist providing the treatment was offered education on appropriate infection control techniques.II.The facility reviewed all residents receiving wound care by therapy for potential infection control issues and none were found.III.The systemic change includes that all dressing changes will be performed in the resident room to facilitate providing a clean field prior to the dressing change.Therapy and nursing staff will be provided education regarding approriate infection control technique during dressing changes, with emphasis on providing a clean field prior to the dressing change.IV.The Director of Nursing or her designee will audit a minimum of 3 dressing changes for proper infection control technique weekly for 4 weeks, then a minimum of 3 dressing changes monthly for 4 months, then one time a month for a duration of 12 months monitoring. The Therapy Supervisor will monitor a minimum of 2 dressing changes weekly for 4 weeks to monitor for proper infection control technique. The audit will then occur for a minimum of 2 dressing changes monthly for 11 months.The results of this audit	04/03/2011

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	PT #1 indicated the therapy department told the staff upstairs that the resident needed cleaned before she came down for treatment, but she continued to come to therapy with feces in her brief. The resident had been sent to therapy with feces in her brief the previous day, also. PT #1 continued on with the treatment of the open wound with the feces on the incontinent brief in the immediate area of the wound. The resident was transferred back upstairs with soiled brief in place at 10 A.M. Interview with PT #1 at 10 A.M. on 3/3/11 indicated she was aware that treatment should not be done with feces in the area, but that was the way the resident was sent for treatment. PT #1 indicated she staged the wound as a Stage 3. Interview with the charge nurse, LPN #1, caring for Resident #113 at 10:08 A.M. on 3/3/11 indicated she had not been told the resident had ever been sent to therapy with an incontinent episode. She had assisted staff in cleaning the resident of feces before breakfast.		will be reviewed in the monthly facility Quality Assurance Committee meeting and the frequency and duration of the audits adjusted as needed.	

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	The facility's policy "SKIN CARE AND PRESSURE/NON-PRESSURE ULCER PREVENTION AND MANAGEMENT PROGRAM," provided at 3/4/11 at 7:50 A.M. and reviewed at 9 A.M., indicated "Skin Care and Early Treatment, Protection, Protect skin from exudates, perspiration, and incontinence." "PRESSURE ULCER TREATMENT, Wound Assessment and Documentation: When assessing a wound and documenting findings, include the following factors: Pain, tenderness or warmth to touch may indicate infection." 3.1-18(b)(1)			